United States Department of Labor
Employees' Compensation Appeals Board

J.H., Appellant	)	
and	)	**Docket No. 15-294**
	)	**Issued: April 24, 2015**
U.S. POSTAL SERVICE, POST OFFICE, Dover, OH, Employer	)	

Appearances:
Alan J. Shapiro, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
CHRISTOPHER J. GODFREY, Chief Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On November 21, 2014 appellant, through counsel, filed a timely appeal from a November 3, 2014 merit decision of the Office of Workers' Compensation Programs (OWCP). Pursuant to the Federal Employees' Compensation Act[1] (FECA) and 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant established more than 21 percent permanent impairment of the right lower extremity and more than 10 percent permanent impairment of the left lower extremity.

On appeal counsel asserts that the November 3, 2014 OWCP decision is contrary to law and fact.

[1] 5 U.S.C. §§ 8101-8193.

FACTUAL HISTORY

On March 16, 1998 appellant, then a 42-year-old letter carrier, filed an occupational disease claim alleging that work duties caused deterioration in the cartilage of both knees. OWCP accepted aggravation of right knee osteoarthritis and hallux rigidus of the left great toe as employment related.[2]

On October 10, 2005 appellant filed a schedule award claim and submitted an August 31, 2003 report in which Dr. Sheldon Kaffen, a Board-certified orthopedic surgeon, advised that maximum medical improvement had been reached and that, in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (hereinafter A.M.A., *Guides*),[3] appellant had 10 percent impairment of the right lower extremity and 2 percent impairment on the left. Dr. Andrea Young, an OWCP medical adviser, concurred with Dr. Kaffen's assessment and advised that maximum medical improvement was reached on August 31, 2003.

By decision dated January 26, 2006, appellant was granted a schedule award for 10 percent impairment of the right lower extremity and 2 percent impairment of the left lower extremity.

On February 8, 2011 Dr. Scott F. Holder, a Board-certified orthopedic surgeon, performed authorized total knee replacement arthroplasty on the right. In an April 13, 2011 treatment note, Dr. Darrin J. Kuczynski, a Board-certified orthopedist, saw appellant for reevaluation of his left great toe. He diagnosed left foot pain secondary to hallux rigidus and osteoarthritis of the left great toe. In a May 12, 2011 treatment note, Dr. Holder reported right knee physical examination findings of good alignment, minimal effusion, flexion to 115 degrees and full extension. He noted that an x-ray that day demonstrated a well-fixed cemented total knee replacement in good alignment with no sign of wear or loosening. Dr. Holder concluded that appellant was doing well following right knee surgery and released him to full duty as of May 16, 2011, with follow-up in one year.

On September 1, 2011 appellant filed a schedule award claim. He submitted a November 16, 2011 report in which Dr. William N. Grant, a Board-certified internist, noted his complaint of pain in the right knee and left great toe and advised that appellant had reached maximum medical improvement. Dr. Grant stated that physical examination demonstrated well-healed surgical scars present on the right knee and left great, synovial change present to both, and limited range of motion of the right knee. He diagnosed primary osteoarthritis of the left leg and left hallux rigidus. Regarding the right knee, Dr. Grant indicated that, in accordance with the sixth edition of the A.M.A., *Guides*,[4] appellant had a class 3 impairment under Table 16-3, Knee

[2] Appellant was removed from the employing establishment effective August 26, 2000 and, following arbitration was reinstated to full duties as a letter carrier in late 2001 or early 2002. He resigned from the employing establishment in March 2002 due to health issues and applied for disability retirement. Since that time appellant has been employed as a substitute teacher, welder's assistant, and in the home repair business.

[3] A.M.A., *Guides* (5th ed. 2001).

[4] *Id.* at (6th ed. 2008).

Regional Grid. He found grade modifiers of 3 for functional history and 4 for physical examination. Dr. Grant concluded that appellant had a net adjustment of 1, for 40 percent right lower extremity impairment. For the left hallux rigidus, he indicated that under Table 16-2, Foot and Ankle Regional Grid, appellant had modifiers of 2 for functional history and physical examination, with a net adjustment of 2, for 7 percent impairment for the hallux rigidus diagnosis. Dr. Grant concluded that appellant had a total 44 percent lower extremity impairment.

On May 10, 2012 Dr. Holder noted that appellant was making satisfactory progress following the right total knee replacement. Right knee examination demonstrated full extension and flexion to 125 degrees, no effusion or calf tenderness, no varus or valgus laxity, no edema, numbness, or tingling in the lower extremity.

On February 7, 2013 Dr. Kuczynski reported a complaint of left foot and great toe pain. Examination showed diminished left great toe range of motion, diffuse soft tissue swelling, pain on extremes, mild tenderness, capsular thickening, and hypertrophic change with no redness, sensory loss, or skin abnormality. Dr. Kuczynski diagnosed left foot pain secondary to hallux rigidus and osteoarthritis of the left great toe.

In a February 28, 2013 report, Dr. Nabil F. Angley, a Board-certified orthopedic surgeon and OWCP medical adviser, noted his review of the record, including Dr. Grant's report. He advised that Dr. Grant's findings did not correspond with those of Dr. Holder and recommended referral for a reliable impairment rating.

In March 2013 OWCP referred appellant to Dr. Manhal Ghanma, Board-certified in orthopedic surgery, for a second opinion evaluation. Appellant did not keep the scheduled appointment, and in an April 10, 2013 decision, OWCP denied his claim for an additional schedule award. He timely requested a hearing.

At the hearing, held on August 19, 2013, appellant testified that he had a work emergency and could not attend the scheduled appointment. He stated that he would be willing to attend a rescheduled examination. In a December 12, 2013 decision, an OWCP hearing representative affirmed the April 10, 2013 decision but noted that appellant would now attend a second opinion impairment evaluation.

An appointment with Dr. Ghanma was rescheduled and appellant attended. In a February 6, 2014 report, Dr. Ghanma noted the history of present illness as provided by appellant, his review of the medical record and statement of accepted facts, and appellant's complaints of pain, balance issues, and the inability to squat or kneel. Right knee examination demonstrated flexion to 110 degrees, no crepitation or instability, and no significant abnormality of gait, stance, or balance. Examination of the left great toe revealed diminished range of motion, evidence of a small spur on the left first metatarsal head, and no sensory deficits. Dr. Ghanma diagnosed status post right total knee replacement, hallux rigidus of the left great toe, and subjective complaints of mild discomfort. He advised that, in accordance with the sixth edition of the A.M.A., *Guides*, under Table 16-3, appellant had a class 2 right lower extremity impairment with a default value of C for 25 percent impairment. Dr. Ghanma found grade modifiers of 1 for functional history, based on a mild problem, 1 for physical examination based on examination findings, and 1 for clinical studies, since appellant's studies confirmed the

diagnosis. He applied the net adjustment formula which yielded 0 and concluded that appellant had 25 percent right lower extremity impairment.

Regarding the left great toe, Dr. Ghanma advised that under Table 16-2, for arthritis of the first metatarsophalangeal joint, appellant had a class 1 impairment with a default value of C for seven percent impairment. He found grade modifiers of 1 for functional history, based on a mild problem, 1 for physical examination, based on examination findings, and 3 for clinical studies, because x-ray demonstrated a severe problem. Dr. Ghanma applied the net adjustment formula which yielded +2 placing appellant in grade E for 13 percent left lower extremity impairment. He concluded that maximum medical improvement was reached six months after the total knee replacement or by August 8, 2011.

On March 13, 2014 Dr. Morley Slutsky, an OWCP medical adviser, Board-certified in occupational medicine, reviewed Dr. Ghanma's report and advised that maximum medical improvement had been reached on February 6, 2014, the date of Dr. Ghanma's examination. He disagreed with Dr. Ghanma's impairment rating. Regarding the right knee, Dr. Slutsky noted that appellant's knee was stable with good hardware placement, and range of motion was within normal limits. He agreed that appellant had a class 2 impairment and that he had a grade 1 modifier for functional history. Dr. Slutsky, however, referred to Table 16-7, and indicated that the appropriate grade modifier for physical examination was 0, stating that range of motion and stability were used to place appellant into the correct diagnosis and class and should not be used again, and that no other deficits were identified. He referred to Table 16-8 and indicated that a modifier for clinical studies was not applicable because an objective study was used to place appellant into the correct diagnosis and this could not be used again. Dr. Slutsky concluded that under Table 16-3, appellant had a final grade of A for 21 percent right lower extremity impairment.

Regarding the left great toe, Dr. Slutsky agreed with Dr. Ghanma that under Table 16-2 appellant had a class 1 impairment for joint arthritis, based on a zero millimeter joint space, which had a default value of 10 percent. He also agreed that appellant had grade modifiers of 1 for both functional history and physical examination. Dr. Slutsky, however, disagreed that appellant had a modifier of 3 for clinical studies, noting that the objective study was used to place appellant into the correct diagnostic class and therefore, under Table 16-8, it could not be used as a clinical studies modifier and was therefore not applicable. He applied the net adjustment formula and concluded that appellant had a net adjustment of zero and, therefore, a 10 percent impairment of the left lower extremity due to great toe joint arthritis.

By decision dated March 20, 2014, appellant was granted a schedule award for an additional 11 percent impairment of the right lower extremity and an additional 8 percent impairment of the left lower extremity, for a total of 21 percent and 10 percent respectively. The award was to run for 54.72 weeks from February 6, 2014 to February 24, 2015. Appellant, through counsel, timely requested a hearing.

In reports dated April 30 and May 2, 2014, Dr. Holder noted that appellant was doing well with regard to his right knee. Knee examination demonstrated no antalgic gait, full extension and flexion to 110 degrees, with possible minimal recurvatum. There was no varus or valgus laxity, no calf tenderness, and no palpable Baker's cyst. Appellant had good ankle

dorsiflexion strength, and alignment was neutral. Right knee x-rays demonstrated a well-fixed knee replacement in good position with no evidence of wear or component loosening. Dr. Holder advised that appellant was unable to walk for prolonged periods of time due to the knee surgery and diagnosed right knee osteoarthritis.

At the hearing, held on September 15, 2014, appellant's attorney maintained that Dr. Slutsky was biased and prejudiced and that he improperly lowered impairment percentages found by Dr. Ghanma.

By decision dated November 3, 2014, an OWCP hearing representative affirmed the March 20, 2014 schedule award decision.

LEGAL PRECEDENT

The schedule award provision of FECA[5] and its implementing federal regulations,[6] set forth the number of weeks of compensation payable to employees sustaining permanent impairment from loss, or loss of use, of scheduled members or functions of the body. However, FECA does not specify the manner in which the percentage of loss shall be determined. For consistent results and to ensure equal justice under the law for all claimants, OWCP has adopted the A.M.A., *Guides* as the uniform standard applicable to all claimants.[7] For decisions issued after May 1, 2009, the sixth edition of the A.M.A., *Guides* is used to calculate schedule awards.[8]

The sixth edition of the A.M.A., *Guides* provides a diagnosis-based method of evaluation utilizing the World Health Organization's International Classification of Functioning, Disability, and Health (ICF).[9] Under the sixth edition, for lower extremity impairments the evaluator identifies the impairment Class of Diagnosis (CDX) condition, which is then adjusted by grade modifiers based on Functional History (GMFH), Physical Examination (GMPE) and Clinical Studies (GMCS).[10] The net adjustment formula is (GMFH-CDX) + (GMPE-CDX) + (GMCS-CDX).[11] Under Chapter 2.3, evaluators are directed to provide reasons for their impairment rating choices, including choices of diagnoses from regional grids and calculations of modifier scores.[12] Section 16.2a of the A.M.A., *Guides*, provides that, if the class selected is defined by

[5] 5 U.S.C. § 8107.

[6] 20 C.F.R. § 10.404.

[7] *Id*. at § 10.404(a).

[8] FECA Bulletin No. 09-03 (issued March 15, 2009).

[9] A.M.A., *Guides*, *supra* note 4 at 4, section 1.3, "The International Classification of Functioning, Disability and Health (ICF): A Contemporary Model of Disablement."

[10] *Id*. at 494-531.

[11] *Id*. at 521.

[12] *Id*. at 23-28.

physical examination findings or clinical studies results, these same findings may not be used as grade modifiers to adjust the rating.[13]

OWCP procedures provide that, after obtaining all necessary medical evidence, the file should be routed to an OWCP medical adviser for an opinion concerning the nature and percentage of impairment in accordance with the A.M.A., *Guides*, with the medical adviser providing rationale for the percentage of impairment specified.[14] In determining entitlement to a schedule award, preexisting impairment to the scheduled member is to be included.[15]

ANALYSIS

The Board finds that appellant has failed to establish more than 21 percent permanent impairment for the right lower extremity and 10 percent permanent impairment for the left lower extremity, for which he received schedule awards. OWCP accepted that he had sustained employment-related aggravation of right knee osteoarthritis and aggravation of hallux rigidus of the left great toe. On January 26, 2006 appellant was granted a schedule award for 10 percent impairment of the right lower extremity and 2 percent impairment on the left, and on March 20, 2014 he was granted a schedule award for an additional 11 percent impairment of the right lower extremity, for a total 21 percent impairment, and an additional 8 percent impairment of the left lower extremity for a total 10 percent impairment.

Regarding the right lower extremity impairment for appellant's knee condition, the Board finds Dr. Grant's November 16, 2011 report of diminished probative value. It is unclear which diagnosis he used to determine the right knee impairment. Dr. Grant indicated that appellant had a class 3 impairment. If he used the "total knee replacement" diagnosis, under Table 16-3, a class 3 impairment would be classified as a severe problem with a fair result, *i.e.*, fair position, mild instability and/or mild motion deficit.[16] The only physical examination finding that Dr. Grant reported was synovial change in the right knee and limited knee range of motion. Section 16.3b and Table 16-7 of the A.M.A., *Guides* describe the rating process for the physical examination modifier.[17] Dr. Grant identified a grade modifier of 4 for physical examination. A grade 4 modifier represents a very severe problem with very severe palpatory findings, consistently documented and supported by observed severe abnormality. Multidirectional instability of the knee should be present with very severe range of motion deficit.[18] Moreover, Dr. Grant's physical examination findings did not correlate with those reported by Dr. Holder, appellant's attending orthopedic surgeon. On May 12, 2011 Dr. Holder reported right knee physical examination findings of good alignment, minimal effusion, flexion to 115 degrees, and

[13] *Id*. at 500.

[14] *See* Federal (FECA) Procedure Manual, Part 2 -- Claims, *Schedule Awards and Permanent Disability Claims*, Chapter 2.808.6(f) (February 2013).

[15] *Peter C. Belkind*, 56 ECAB 580 (2005).

[16] *Supra* note 4 at 511.

[17] *Id*. at 517

[18] *Id*.

full extension. Table 16-23 indicates that 115 degrees of flexion is normal.[19] Dr. Grant did not provide specific range of motion measurements. Dr. Holder also noted that an x-ray demonstrated a well-fixed cemented knee replacement in good alignment with no sign of wear or loosening. Dr. Grant described no x-ray findings. Dr. Holder concluded that appellant was doing well following the right knee surgery and released him to full duty as of May 16, 2011, with follow-up in one year. Finally, Dr. Grant did not include a mathematical explanation of the net adjustment formula. The Board has long held that an attending physician's report, such as Dr. Grant's November 16, 2011 report, is of little probative value where the A.M.A., *Guides* are not properly followed.[20]

Regarding the hallux rigidus of the left great toe, while Dr. Grant indicated that under Table 16-2 appellant had modifiers of 2 for functional history and physical examination, the physician did not identify a specific diagnosis or a class of impairment. He merely concluded that appellant had a net adjustment of 2 for seven percent impairment of the left lower extremity. Therefore, as Dr. Grant again did not properly follow the A.M.A., *Guides*, his calculation for appellant's left great toe impairment is of diminished probative value.[21]

Dr. Ghanma, an OWCP referral physician, advised on February 6, 2014 that knee examination demonstrated flexion to 110 degrees, no crepitation or instability, and no significant abnormality of gait, stance, or balance. He diagnosed status post right knee replacement surgery and advised that, in accordance with the sixth edition of the A.M.A., *Guides*, under Table 16-3, appellant had a class 2 impairment with a default value of C for 25 percent impairment.[22] Dr. Ghanma found grade modifiers of 1 for functional history, based on a mild problem, 1 for physical examination based on examination findings, and 1 for clinical studies, since appellant's studies confirmed the diagnosis. He applied the net adjustment formula which yielded 0 and concluded that appellant had 25 percent right lower extremity impairment for the diagnosis of right total knee replacement. As noted in the discussion below, Dr. Ghanma also failed to properly apply the A.M.A., *Guides*.

Dr. Slutsky, an OWCP medical adviser, reviewed the medical record, including Dr. Ghanma's report and provided proper rationale for the percentage of right lower extremity impairment.[23] In a March 13, 2014 report, he stated that maximum medical improvement was reached on February 6, 2014, the date of Dr. Ghanma's examination. Dr. Slutsky noted that appellant's knee was stable with good hardware placement, and that range of motion was within normal limits. He agreed with Dr. Ghanma that appellant had a class 2 impairment and a grade 1 modifier for functional history. Dr. Slutsky referred to section 16.3b and Table 16-7, and

[19] *Id*. at 549.

[20] *Richard A. Neidert*, 57 ECAB 474 (2006).

[21] *Id.*

[22] On an attached impairment worksheet, Dr. Ghanma identified that class for a total knee replacement diagnosis as class 1. He, however, identified the grade as C with a default value of 25 percent which, under Table 16-3, is a class 2 impairment. *Supra* note 16.

[23] *See* Federal (FECA) Procedure Manual, *supra* note 14.

properly indicated that if range of motion and stability were used to place appellant into the correct diagnosis and class, they should not be used again.[24] As no other deficits were identified, he found no grade modifier for physical examination. Dr. Slutsky also disagreed with Dr. Ghanma regarding the clinical studies grade modifier. He referred to section 16.3c and Table 16-8 and properly found that a modifier for clinical studies was not applicable because an objective study was used to place appellant into the correct diagnosis and could not be used again.[25] Dr. Slutsky concluded that, under Table 16-3, appellant had a final grade of A for 21 percent right lower extremity impairment.

Dr. Slutsky agreed with Dr. Ghanma that under Table 16-2, for arthritis of the first metatarsophalangeal joint, appellant had a class 1 impairment. Dr. Ghanma incorrectly noted that the default value for this diagnosis was seven percent. Dr. Slutsky, however, properly identified the default value as 10 percent.[26] He also agreed with Dr. Ghanma that appellant had grade modifiers of 1 for both functional history and physical examination. Dr. Slutsky, however, disagreed that appellant had a modifier of 3 for clinical studies, noting that the objective study was used to place appellant into the correct diagnostic class and properly found that, in accordance with section 16.3c and Table 16-8 of the A.M.A., *Guides*, this could not be used as a clinical studies modifier and was therefore not applicable.[27] He properly applied the net adjustment formula and concluded that appellant had an adjustment of zero for 10 percent impairment of the left lower extremity due to great toe joint arthritis.

The Board concludes that the medical adviser applied the appropriate sections of the A.M.A., *Guides* to the clinical findings of record.[28] Therefore, OWCP's November 3, 2014 decision affirming the March 20, 2014 schedule award is proper under the law and facts of this case.

Appellant may request a schedule award or increased schedule award based on evidence of a new exposure or medical evidence showing progression of an employment-related condition resulting in permanent impairment or increased impairment.

CONCLUSION

The Board finds that appellant has failed to establish more than 21 percent impairment of the right lower extremity and 10 percent impairment on the left, for which he had previously received schedule awards.

[24] *Supra* note 4 at 517.

[25] *Id*. at 518-19.

[26] *Id*. at 511.

[27] *Id*. at 518-19.

[28] *See W.M.*, Docket No. 11-1706 (issued March 20, 2012).

ORDER

IT IS HEREBY ORDERED THAT the November 3, 2014 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: April 24, 2015
Washington, DC

Christopher J. Godfrey, Chief Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board